

SUCCESS MAY NOT BE ENOUGH

In this month's issue of *ImpAct*, five of the six stories in paper and on the Internet come from groups wanting to tell their NHS colleagues of their success. Not boastfully to improve their own image, but to share mechanisms of success with others. When *ImpAct* started two years ago, we had to dig out all the stories.

This change is terrific, and shows that in the NHS people want to make the best the norm. But success may not be enough. This may be the last print edition of *ImpAct*, but we keep trying. We are developing more on the *Bandolier* Internet site, so keep the stories coming.

Electronic ImpAct

This month we have added three new pieces to the *Bandolier/ImpAct* website. Two are reports of experiences those involved are keen to share with colleagues across the NHS. We have also posted a second paper in the **Delivering Better Health Care** series.

Seeing the wood for the trees offers a broad practical picture of the influences on, and the tasks involved in implementing change in clinical practice. Over the next few months we will be completing the series with a third paper that will offer a more detailed tutorial on the tasks involved, drawing on examples from across the NHS.

A little bit of salt

The Northumberland PCG chose to use a visual aid - a small bottle of salt - in an initiative to change the behaviour of clinicians and patients and for them to recognise how much salt patients could take in from their prescription medicines. The case study describes the background to the work, the way the initiative was managed by the team, progress so far, and some of the lessons from the work.

Getting hold of heart disease in primary care

The Freshford practice in rural Essex decided they wanted to look for ways to promote cardiovascular health of their patients not only by sticking to clinically accepted standards of care, but also by promoting a population approach to risk reduction. One of the most encouraging symbols of progress has been the creation of an Expert Patients Group involving heart patients which is starting to develop its own identity and work programme.

SMALL PRACTICES TAKING BIG STEPS - TOGETHER

Improving prescribing across a group of small practices in the North Walsall Primary Care Group.

Why was the initiative launched?

The move to create primary care groups prompted 25 mainly single-handed GPs in Walsall to propose that they should form one PCG. They saw few attractions in joining with larger practices without much in common with them. They were a stable group and all knew each other well. They thought that success would be more likely if they could show that they could work together to improve the quality of care for patients. They needed a focus for their efforts: aspects of prescribing seemed to be a promising area.

What was done?

Tom Dent, the clinical governance lead, started things rolling. The first step should be a meeting to debate possible topics. He wanted his fellow GPs to have an opportunity to have their say so chose not to present his own ideas. The aim was to achieve a consensus for action with ownership of the agenda rather than to sell a package of proposals. A work programme that could be monitored was a specific concern. Six of the twenty practices did not have IT systems so reliance on PACT data would be essential.

The meeting was held in February 1999 and was attended by about half of the GPs in the shadow PCG. The agenda included presentations by colleagues from local hospitals and the health authority on a range of topics. Cardiovascular, GI and mental health were addressed, as well as general prescribing issues such as the list of drugs of limited value identified by the Audit Commission. Evidence about the effectiveness of specific interventions was described.

In this issue

Electronic ImpAct	p. 1
Improved prescribing in small practices	p. 1
A shared approach to better prescribing	p. 3
Re-engineering A&E for the better	p. 5
Answering real problems in primary care	p. 7

*The views expressed in *ImpAct* are those of the authors, and are not necessarily those of the NHSE*

The challenge facing the group was illustrated by information about the variations across the practices in the PCG.

Suitable targets for attention

After the presentations, those present split into two groups to debate issues and identify themes for action. A range of issues was identified, including broad policy issues, such as the need for more information sharing across practices, the development of local guidelines and patient education. There was consensus that four specific prescribing issues merited attention:

- ◆ To increase the prescribing of generic drugs.
- ◆ To reduce antibiotic prescribing.
- ◆ To reduce prescribing drugs of limited clinical value.
- ◆ To increase the use of low dose PPIs.

A second meeting in April 1999 addressed the four specific prescribing issues in more detail and plotted a way forward. Dennis Ray, a lay member of the PCG, suggested that role-play could be used to illustrate the challenge of changing prescribing practices. This illustrated problems faced by a GP who was reluctant to prescribe the antibiotics demanded by an elderly patient. The meeting was well attended with all practices represented. The use of role-play was a success, and got over the message without lecturing.

GPs agreed to review their prescribing practices in the four areas. Targets would be set based on trends data available against a 1999 baseline. For example, the group agreed a target generic prescribing rate of 70% across the PCG as a whole. The targets would be followed up in two ways:

- *Wing Koo*, the newly appointed PCG Pharmacist would talk to GPs individually about their own prescribing practices and offer practical help, such as the handling of repeat prescriptions and explanations for patients.
- *Tom Dent* would provide regular reports at the monthly GP Forum to show progress made and congratulate colleagues who were making good progress.

Did it work?

In a short time encouraging changes in the prescribing practices have become evident. There was significant progress towards the PCG targets (Table 1) allowing more challenging targets to be set for future years. Care is being taken to ensure that the targets are realistic. For example, there is doubt about whether a target of more than 75% for generic prescribing is sensible. This might be the ceiling. Further effort here might be counter-productive.

Reducing variations across the PCG

Before the initiative was launched there were significant variations in prescribing across the PCG. There is particular satisfaction locally that these variations are narrowing (Table 2). All practices performed well overall. Some concentrated their efforts in certain areas and produced significant prescribing changes. The changes have been achieved by the GPs themselves without major external efforts to influence them. Engaging their interest, explaining the benefits and demonstrating the scale of local variations have been sufficient.

Some of the changes are quite dramatic:

For generic prescribing between February 1999 and June 2000
Dr A has increased the proportion by 47%
Dr B has increased the proportion by 28%

For antibiotic prescribing between June 1999 and June 2000
Dr B has achieved a reduction of 45%
Dr C has achieved a reduction of 26%

For drugs of limited clinical value between February 1999 and June 2000
Dr D has achieved a reduction in expenditure of 51%
Dr E has achieved a reduction in expenditure of 46%

For the use of low dose PPI between June 1999 and June 2000
Dr F has increased prescribing by 195%
Dr G has increased prescribing by 200%.

Table 1: North Walsall PCG - changes in prescribing

Prescribing Indicators	Baseline Feb 1999	Performance 1999 v 2000	Target 1999 v 2000	Percent change 1999-2000
Generic rate	61%	70%	65%	+9
Antibiotic items per 1000 STARPU	416	308	360	-19
Drugs of Limited Clinical Value cost (p) per PU	27	21	22	-22
Proton Pump Inhibitors prescribed as low dose*	Not available	50%	40%	+28

Notes

Prescribing indicators from the incentive scheme 1999/2000 (February 1999 – March 2000) taken from PACT data

Percent Change is based on prescribing performance from February 1999 to March 2000. Baseline taken in February 1999 and compared with data in March 2000)

* PPI data from June 1999 onwards.

Table 2: North Walsall PCG - illustrations of variations in prescribing

	Feb-99	Dec-99	Jun-00
Generic prescribing rates			
Lowest	42	49	61
Highest	74	74	75
PCG mean	64	66	70
Expenditure on drugs of limited clinical value (p)			
Lowest	0.04	0.05	0.03
Highest	0.50	0.43	0.44
PCG mean	0.27	0.23	0.20

These changes have stimulated greater interest across the local GP community in prescribing issues. Discussion at the regular GP Forum is increasingly ambitious with GPs keen to explore other ways to improve the quality of the care they provide for their patients. Currently the use of blood tests and hospital referrals is being compared.

Tips for success

- ✓ Take care with communications. Make sure the message is clear and gets to the intended ear.
- ✓ Use a two-tier communication strategy. Address individuals and groups.
- ✓ Encourage debate and openness, but remember that getting suitable agreement and action is what matters, not winning the argument.
- ✓ Try different techniques to prompt discussion. The PCG set up a role-play (GP / patients) to illustrate the point.
- ✓ Peer pressure is probably stronger than financial perks. Individuals may be uncomfortable being the outlier.
- ✓ Know when to stop pushing your agenda. Don't brow beat people. It's better to withdraw and try again later.
- ✓ Anonymous presentations of trends can be as powerful as named data.
- ✓ Openness about individual performance encouraged interest and participation in this group.

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ImpAct bottom line

⇒ Get agreement that something needs to be done before pushing for endorsement of detailed objectives.

A SHARED APPROACH TO BETTER PRESCRIBING

Collaboration between two practices in Exeter points the way to rational prescribing

Why was the initiative launched?

Information presented at a meeting in November 1999 of the Prescribing Leads from the practices in the Exeter Primary Care Group showed widely different prescribing practice and costs. It raised questions in the minds of the Prescribing Leads from two practices (Dr Gill Stowell, Ide Lane Surgery and Dr Phil Evans, St Leonard's Medical Practice) about how practices similar in size and philosophy could have widely different prescribing costs. PACT data illustrated the differences but could not explain them.

At the time the North and East Devon Health Authority offered to arrange and fund away-days for individual practices to explore prescribing issues. The two Prescribing Leads suggested that a joint away-day might help understand their differing prescribing costs. They might learn about improving quality and decreasing costs of prescribing.

What was done?

To ensure maximum attendance and allow adequate time for preparation, a date six months ahead was chosen (June 2000). A series of meetings proved to be essential stepping stones towards a successful event.

Five key planning meetings

The *first* meeting (March 2000) was a brainstorming session to enable the Prescribing Leads to sketch a broad picture of the issues that might need addressing. Various practice characteristics, like demography and organisation, were identified as possible contributory factors and each practice assembled relevant data. In addition, the top 10 drugs for each practice, and costs for each BNF therapeutic group were compared with the Exeter PCG average.

The *second* meeting (April 2000) involved the pharmaceutical advisers from the Health Authority and the PCG. A review of the PACT data for the two practices made focus on the three highest cost BNF therapeutic groups (Cardiovascular, CNS and GI) sensible. Decisions were also taken about practical points such as venue, participants and who should chair the event. The discussion was informed by experience from other local prescribing away-days.

At the *third* meeting (May 2000) the Prescribing Leads were able to review preliminary data about general characteristics of the practices and about prescribing in each of the three highlighted groups. The diagnosis and management of disease as well as prescribing would need to be addressed. Progress would depend on the extent to which the practice would be willing to share detailed data about the quality of care: a potentially sensitive issue. It seemed wise at this stage

to check that all the partners involved were willing to proceed. Concerns proved unfounded: all the partners agreed that the session and the sharing of data should go ahead.

A final preparatory meeting (May 2000) allowed the finishing touches to be made to the arrangements for the day, including the structure of the session, the agenda, and the scope of background information for each participant.

Was the away day a success?

The away day was held in June 2000. On the day each participant was given a detailed information pack prepared by the health authority, including PACT data, and relevant guidelines. (Subsequent comments suggested that it might have been better to send these out in advance!).

Most GP principals attended along with a strong representation of other disciplines, including nurses and clerical staff. Retained doctors were invited but were unable to attend; locums should probably have been involved. In total 19 participants from the two practices attended. To get the day off to a good start an informal opening session consisted of an ice-breaking activity to get people talking!

The Chairman, Dr Nick Bradley, a GP from Ide Lane Surgery, set the scene and the ground rules: open discussion about the issues would be encouraged. The product would be plans for action within the two practices: it was not simply a talking shop! The two Prescribing Leads illustrated the strengths and weaknesses of each practice. Participants then identified four sets of factors which influenced prescribing, ie those related to patients, to doctors, to the practice and external factors. Discussion then focused around the three chosen topic areas.

Cardiovascular disease

The opening presentation demonstrated the quantity and quality of hard evidence available. Participants agreed it was easier to be rational when the evidence was clear-cut. In several areas the practices' use of particular drugs was similar, like the use of statins and of ACE inhibitors in hypertension. There were also wide variations. One practice seemed to implement the findings from single studies (HOPE study) promptly whereas the other preferred to wait for consensus reviews before changing practice.

Central Nervous System

Comparisons of the use of traditional and atypical antipsychotics and the use of tricyclics and SSRIs from the practices and health authority perspective stimulated this part of the discussion. Information was also presented about the advantages and disadvantages of tricyclics against SSRIs and guidelines about the management of depression.

Participants argued that evidence was not as strong in this area and what there was tended to come from secondary care: it didn't translate well to primary care. There was a lack of evidence directly relevant to primary care. Prescribing seemed to be guided by emotion and anecdote rather than evidence; for example the practices had reached dif-

Table 1: Practice Action Plans - some typical commitments

- | | |
|---|--|
| 1 | To review all patients on more than 80 mg of frusemide and consider use of ACE inhibitors |
| 2 | To review statin prescribing and ensure use of 20 mg and 40 mg dose instead of multiples of 10 mg or 20 mg |
| 3 | To update practice formulary with treatment of choice: losartan becomes candesartan |
| 4 | Practice/district nurse to check dressing prescriptions before they are sent off. |
| 5 | Liaise with consultant psychiatrist with regard to atypical antipsychotics |
| 6 | Use fluoxetine as a first choice SSRI and explore non-drug treatment of depression. |

ferent conclusions about the advantages and disadvantages of SSRIs in depression. The high number of psychotic patients in one practice had significant impact on prescribing costs and better dialogue with secondary care was needed.

Gastrointestinal

Role-play of a consultation, focused on an elderly patient insisting on long term PPI treatment with a high dose, introduced this part of the session. Information about current prescribing practice and work on new guidelines was also presented.

Participants agreed this was a high cost area where change may be required, but it was difficult to persuade patients to change once they were established on a PPI. Treatment often seemed to be focused on the symptoms rather than disease. One practice had always followed a step-up approach to dyspepsia. The other practice was more flexible and recognised that it needed to review its management of dyspepsia. Participants agreed that this was an area worthy of attention in both practices.

Action Plans

For the final part of the day each practice met as a team to review what they had learnt during the day and to draw up action plans. Each practice identified a range of issues they needed to address and take forward. The issues ranged from the need to update one of the practice's formulary to the review of prescribing for individual patients (Table 1). The plans were then shared with the other practice. Arrangements would be put in place to monitor progress and allow the practice to meet again to revisit the issues.

At the end of the session participants said how pleased they were with the sessions. It had been a great success. On the three main dimensions - relevance, interest and usefulness - participants rated the session highly. Comments included:

- *It has refreshed my interest in prescribing*
- *Joint hospital/primary care events would be useful*
- *Have it on a rainy day*

Some participants suggested the need for other similar sessions to enable the two practices to meet and share information and ideas. There was confidence that the action plans would be honoured. A joint away-day had proved to be a valuable way of sharing information, debating the issues and identifying what needed to be done.

Tips for success

- ✓ Do your homework and assemble sufficient, but not too much, information to stimulate discussion.
- ✓ Value the contribution that can be made by health authority prescribing departments.
- ✓ Give plenty of notice.
- ✓ Plan thoroughly: make sure that the discussion is focused to facilitate the agreement of realistic action plans.
- ✓ Make sure that the session has an action focus: allow time in the agenda for the agreement of action points.
- ✓ Allocate roles at the session carefully: make best use of local skills such as facilitation and presentation.
- ✓ Make sure that you find a comfortable venue for the event that is not overtly expensive.

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The following information is available

- Illustrative action plans.
- Information pack provided to participants.
- The information pack provided for participants.
- Specification of the data shared by the practices.

ImpAct bottom line

⇒ Don't be deterred by a belief that practices won't share information – success can be assured if you prepare well.

MAKING A&E A BETTER PLACE

Improving the quality of A&E services at Whittington Hospital in North London

Why was the initiative launched?

Problems in the A&E at Whittington Hospital were highlighted by an Audit Commission study in 1996. The Department performed poorly on a number of counts, including waiting times. Morale was low, budgets overspent, and the rest of the hospital thought it provided a poor service. An internal review suggested the main problems to be the wrong balance of medical and nursing staff, and a mismatch of staffing levels and workload. Changes were needed if A&E was to meet expectations of staff and community.

How was the work taken forward?

In 1998, senior Trust managers agreed that the development of A&E was a top priority. Improvements were needed in staffing, the service provided, and to its relationship with other Departments. Over the following two years five parallel tasks have been tackled.

A new nursing role in A&E

The *first* and most significant task was to develop the nursing role in A&E. Dee Hackett, a senior nurse, was appointed to lead the work. She faced two main problems.

Nurses were not on duty when most needed. The internal review showed that the nurse complement at night was 70% of the day but consultations were much lower (Table 1). Rotas were unchanged for many years and staff worked in the same groups. There was little flexibility and staff movement. Implementation of new rotas encountered a few problems. Some staff were reluctant to change, and left. The majority adapted quickly to the new rotas.

Nursing skills were not used to the best effect. The solution was to develop a new role for the Emergency Nurse Practitioner. A specification was drawn up and agreed by senior nurses and medical staff. The aim was to give the emergency nurse practitioners autonomy to deal with minor problems, order investigations and discharge patients. Five volunteers from existing staff of F and G grade nurses trained for the new posts. In 1998 there was no recognised training course for this role so they were trained in house initially (courses are now organised by the English National Board). Other front line nurses were trained to perform triage to the Emergency Nurse Practitioner or doctor.

Table 1: Staff number and workload

	Figures for one 24-hour period in 1997		
	8.00 am – 4.00pm – 00.00 – 4.00pm 00.00 08.00am		
Arrivals	75	68	19
Departures	61	86	36
Staff on duty	26	32	18

Table 2: Reducing transit time in A&E: selective months

	Mar-98	Jun-98	Sep-98	Dec-98	Mar-99	Jun-99	Sep-99	Dec-99
Average waiting time (mins)	110	105	95	95	90	85	90	90

Pathways to better care

The *second* piece of work was to create a series of care pathways. This work, led by Dr Jennifer Worrall in cooperation with Dee Hackett, created a series of protocols to guide and improve quality of care for patients admitted through A&E. Teams from across the Trust contributed. Topics covered include MI, unstable angina and fractured neck of femur.

Building on the work on pathways, the *third* task was to improve liaison between staff in A&E and the other departments. This prompted new arrangements for multi-disciplinary teaching. It also led to the introduction of new arrangements for managing medical admissions. Consultants are now more involved in these decisions as they are taken within A&E. They are regular visitors to the Department.

The *fourth* task was to review medical staffing in A&E. The internal review highlighted excessive use of locums as one of the factors contributing to the continuing overspends. Training was improved with protected time for all medical staff and a new permanent SpR post approved. Three staff grade doctors have since been appointed providing better supervision for senior house officers.

Creating a better environment in A&E

The *fifth* task was to look at the physical condition of the Department - was it good place in which to work or to be a patient? The A&E manager decided to use environmental consultants to help redesign the facilities, including discussion with patients as ideas were developed. Their recommendations included soothing colours, new curved seating, removal of all the '*Do not*' signs, more privacy for patients and separation of children from adult patients. Screens now separate blue light ambulance arrivals from the waiting room. The overall cost of the changes was about £50,000.

Has A&E performance improved?

The initiatives have had a marked impact on the performance of A&E. It is no longer a place to avoid for staff or patients. Some key indicators of that success are:

- ◆ Improved patient flow (Table 2).
- ◆ Reduced transit time for non-admissions. A 20% reduction despite growing attendance.
- ◆ Budget management has improved with less use of temporary staffing (Table 3).
- ◆ Greater integration of A&E staff within the hospital.

The initiative is a good example of what clinical governance should mean at operational level. Structural change was achieved without new buildings and without much in the way of new staff. It was rebuilt from the inside by adapting facilities, developing existing staff roles and looking at the service from the patients' perspective. It facilitated:

Table 3: Staffing costs (£)

	1997-98	1999-00
Medical staff	619,000	724,000,
Medical locums	80,000 (13%)	66,000 (9%)
Nursing staff	1,179,000	1,412,000
Bank and agency nurses	362,000 (31%)	359,000 (25%)

- ◆ Efficient use of resources by matching staff to demand
- ◆ Development of staff by creating a new role of the Emergency Nurse Practitioner
- ◆ Better education and training for all professional staff with protected time for training
- ◆ The implementation of evidence based practice in the design of pathways and protocols
- ◆ Better team work both in A&E and across the hospital
- ◆ Better facilities for patients with a comfortable environment and more privacy.

The Department is now seen as a good place to work. There are no vacancies. Morale in the Department has improved dramatically with more smiling faces!

Tips for success

- ✓ Make sure that you understand the problem. Time spent doing your homework is never wasted.
- ✓ Find the right people to lead the work. The use of outsiders may help speed the process.
- ✓ Everyone works better if the environment is comfortable. Changes may not be costly.
- ✓ Be innovative. Explore how a new role might make better use of skills already available.
- ✓ Make sure that people have time to contribute. Find ways to legitimise time away from patients.

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ImpAct bottom line

⇒ Don't expect a quick fix – many problems require a multi faceted approach and take time

ATTRACTING THE RIGHT QUESTIONS

Developing a rapid source of advice for GPs in Gwent

Why was the initiative launched?

Time is a precious commodity in primary care. GPs are seemingly faced with a never-ending queue of patients waiting for their advice and help. GPs are accustomed to the routine, but unusual situations generate uncertainty. Although they may well know the questions: *how to make a diagnosis? what is the most effective treatment? which is the most suitable drug?* They rarely have time to pursue them and find the right answers. Those promoting evidence-based practice talk of five steps, but for many GPs two of these, finding and appraising evidence, are very difficult. If the quality of care is to be improved ways need to be found to promptly answer questions for GPs.

Finding a way forward

Discussions across the primary care practices in Gwent showed that there was a need for an information system geared to GPs' needs. Previous efforts had concentrated too much on providing information *in the belief* that it was needed. These discussions encouraged the Gwent Primary Care Clinical Effectiveness Team (known as TRIP - Turning Research into Practice) to explore ways in which they could offer timely support to GPs. Their question was *Could we answer the sorts of questions posed by GPs and provide answers within a timeframe acceptable to GPs?* In 1997 they set up the ATTRACT (Ask Trip To Rapidly Alleviate Confused Thoughts) project, designed to provide rapid evidence-based summaries to clinical questions.

How would ATTRACT operate?

The service operates through a telephone helpline. GPs were invited to telephone, fax or e-mail their clinical questions to ATTRACT. To get the service going, staff from TRIP arranged a series of practice-based meetings to explain the nature of the new service. The questions would be sent to an experienced information manager who would review them to ensure that they were answerable. Problems would be discussed with the GP for clarification if needed. Assuming that the questions had not been posed before, a rapid search of the literature using the key information sources would be set in hand.

The key sources used would be MEDLINE (both Ovid and PubMed formats), The Cochrane Library, Best Evidence, Embase and the TRIP Database. The expectation was that searches would take no more than two hours and could be significantly shorter if, for example, a recent systematic review was found. The information was appraised, summarised on one side of A4 and faxed to the GP. The target was a total turn around time of no more than six hours. The plan included the creation of a database of questions and answers on the TRIP website. Answers would thus be avail-

able to others and a log would show the number of visits to each answer. How many people were interested in each question?

Is ATTRACT helping GPs?

The service was launched in January 1997 and is proving to be very popular with GPs in Gwent. Since it was set up about 1000 questions have been answered. Use has grown to a steady rate of about 20-25 a month. The material now covers a wide range of issues. As one GP said "*It's brilliant for GPs who don't have time or the resources locally to look for information*". Indeed, few have the skills required or the equipment needed. The service is proving to be an essential part of the primary care tool-kit.

Its value is demonstrated by comments by some of those who use the service:

- ◆ It makes EBM practical for GPs by tackling two of the labour intensive stages (finding and appraising) of evidence-based practice. GPs can now concentrate on delivery.
- ◆ The information often confirms first thoughts, but when one is not sure. It has helped to remove some uncertainty.
- ◆ There is no doubt that it enhances one's credibility with patients. They appreciate the trouble taken to check the facts.
- ◆ It is helpful when acting as advocate for patients. Patients may approach their GP for advice about choices in their treatment and / or understand information from the hospital. Patients may not be sure about a new drug being prescribed.
- ◆ It helps Local Health Groups respond promptly to requests from GPs for advice and avoids them having to spend time searching for evidence. They can offer a much more responsive support service.

It is difficult to measure the impact of the service but it has helped to develop the willingness of GPs to ask questions. GPs are confident that it has helped them improve the quality of their decision making.

The information is essentially addressing the specific situation of an individual patient. But it may also have wider validity. Some practices are starting to look at how they can use the information more generally to improve care to patients.

Evaluating the service

TRIP was keen to gauge the support for the service from GPs: was it worth carrying on? In 1997 they sent a questionnaire to the first 15 general practitioners who used the service about two months after their enquiries. A year later, identical questionnaires were sent to those that had asked the 35 most recent questions. The response is encouraging. Forty-two of the 50 (84%) general practitioners replied. Twenty-nine rated the service very useful while the remaining thirteen (31%) rated the service useful. All the respondents rated the service as very quick or quick and all reported

that they would use the service again. A significant proportion (60%) indicated that they changed their practice as a result of the information presented to them. Most of the rest said that they were already practising in line with the evidence supplied.

Another measure of the interest can be seen by the visits to the website. The most popularly visited questions on the website (Table 1) during the first two years have shown the need for information about less glamorous areas (such as proctalgia fugax or eustachian tube dysfunction) rather than the more commonplace topics, such as coronary heart disease, asthma and diabetes.

The initiative has shown that a query-answering service built around a telephone helpline can produce prompt advice based on data from validated sources. The service is labour intensive, but a competent individual can search and summarise approximately 15 questions a week. Experience has shown that the same question is asked by different GPs with the answer now readily available on the database.

Currently NOISE (National Organisation for Information Support for Effectiveness), a group representing query-answering services from across the UK is creating a database of questions and answers. It is helping to avoid the duplication of effort and to improve turn around times. It is exploring whether it could offer a service to validate answers, although experience shows that those running such services do not always like using other people's answers!

What next for ATTRACT?

ATTRACT has secured funding for a further two years to extend the service across Wales. Two full-time searcher/summarisers are being appointed. A squad rotation system is being introduced within TRIP to spread the work and

Table 1. Number of times the most popular questions were accessed on the TRIP website during 1997 and 1998

Question	Number
Is there any link between gout and diet?	1483
Is there any information about the effectiveness of Xenical?	616
Which is best depression scoring system?	588
What are the risks of flying while pregnant?	581
Do decongestants help in people with eustachian tube dysfunction?	574
Are there any effective treatments for proctalgia fugax?	464
What is the effectiveness of combined paracetamol and opiates?	459

reduce fatigue. A new website will support the extended service with questions classified (e.g. CVD, cancer etc) to allow easier searching. Moreover people will be able to register to receive regular e-mail updates of new questions/answers. There will also be a section to spotlight areas where there is little helpful research. This should prompt researchers to find answers and influence the NHS R&D agenda.

A more in-depth service is also planned, called AIR (ATTRACT Inspired Reviews), to carry out more in-depth reviews on the most frequently visited questions on the website. Ways of taking advantage of the educational value of ATTRACT are also being explored, for example as a reflective tool within peoples' portfolio development.

A challenge for primary care organisations

Providing a service like ATTRACT may be as important in improving the quality of care as the current concentration on systems to force-feed information to unwilling clinicians. Many studies show that unsolicited information is unlikely to change practice. There is a real opportunity now for all new primary care organisations to offer something that has been proven to be helpful to GPs.

ATTRACT, and indeed other similar services, have shown what is possible. But many local services have fallen by the wayside as continuing problems about long-term funding have gone unresolved. It is often seen to be others people responsibility. The support offered by NOISE may make it timely for primary care organisations to think again about how they could provide this type of support for local GPs. NOISE could ensure that this particular wheel is not continually re-invented all over the NHS.

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ImpAct bottom line

⇒ Find ways to remove uncertainty: a critical stage in the development of good practice.

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